Health Care Planning and Accountability Advisory Council
Friday, January 27, 2012
Department of Administration Conference Room "A"

Co-chairmen: Steven Costantino, Secretary, Executive Office of Health & Human Services; Christopher Koller, Commissioner, Office of the Health Insurance Commissioner

Attendees: Peter Andruskiewicz, Douglas Bennett, Kenneth Belcher, Jodi Bourque, Esq., Al Charbonneau, Beth Cotter, Stephen Farrell, Michael Fine, MD, Patricia Flanagan, MD, Marie Ganim, Ph.D., Robert Hartman, Jane Hayward, Gloria Hincapie, Eve Keenan, Ed.D, RN, Dale Klaztker, Ph.D., Donna Policastro, RNP, Edward Quinlan, Mark Reynolds, and Fox Wetle, Ph.D.

Staff in attendance: Michael Fine, MD, Director of Health; Melinda Thomas, Senior Policy Advisor, Department of Health; Michael Dexter, Chief, Office of Health Systems Development, Department of Health; Amy LaPierre, MSW, Chief, Family Health Systems, Executive Office of Health & Human Services (Medicaid), Elizabeth Shelov, Chief, Family Health Systems, Executive Office of Health & Human Services.

Introduction

The Council meeting was convened at 1:10 pm by Co-chairmen Steven Costantino and Christopher Koller. Secretary Costantino welcomed the group and began with an explanation of the statutory basis for the Council. He stated that the contributions of the members are very much appreciated.

Commissioner Koller also welcomed the group and indicated that the "full house" in the room reflects the importance of the Council's work.

Discussion Points

Dr. Michael Fine presented a PowerPoint on "How Health Planning Can Be Used in State Government." {Slide presentation is available online: www.health.ri.gov } Health planning is critical to the work of state government. Dr. Fine discussed the "certificate of need" {CoN} process established under Chapter 23-15 of the Rhode Island General Laws, as amended. Its purpose is to provide for the development, establishment, and enforcement of standards for the authorization and allocation of new institutional health services and new health care equipment.

Dr. Fine discussed the decline in birth rates {12,709 to 11,166 between 2001 and 2010} and noted that the data suggest a substantial change in the need for health care facilities. Demographics have also shifted such that Rhode Island's face reflects a younger, Hispanic population with very different health care needs. We have to plan and anticipate the changing needs of this population, according to Dr. Fine.

Dr. Fine discussed the increasing need for primary care: What models should be encouraged? What disciplines should be included? And where should sites of care be located?

Dr. Fine discussed the "Triple Aim", which he defined as improved outcomes, decreased costs, and the best personal experience of care.

Melinda Thomas, Senior Policy Advisor, reviewed a brief history of health planning activities in Rhode Island. {See additional slides on the website noted above}.

Highlights: Chapter 23-81 of the Rhode Island General Laws, as amended, authorizes the appointment of a Council that shall develop a process for establishing appropriate supply and allocation of resources to meet the population's needs effectively, efficiently, and affordably.

In the Winter of 2006-2007, the Director of Health {then Dr. David Gifford} charged a committee with writing a plan of action for health care planning. This final report is on the Department of Health's website and its key findings included: 1. The health care system will not be transformed without collaboration and robust planning; 2. The state does not have the capacity to establish a comprehensive health planning process; 3. Addition statutory authority is recommended to meet the goals of the report.

The vision, values, principles, and objectives of the planning group were stated in the 2007 report as follows: "Every Rhode Islander should have access to high quality, affordable health care, delivered at the most appropriate time and place."

Commission Koller indicated that the advice and recommendations of the Council might be implemented without additional statutory authority, if the Council's advice is sufficiently clear and direct to implement. He indicated that the Office of the Health Insurance Commissioner (OHIC) is a "customer" for the work of this Council.

In the 2011 session of the General Assembly, Chapter 23-81 was revised and $150,000 was allocated for health planning activities. Secretary Costantino indicated that the $150,000 will catapult the state into a more comprehensive planning process over the next three years. It will support the basis for the next phase of health planning.

Statewide Health Planning Request for Proposals (RFP)

Secretary Costantino noted that staff has written a request for proposals (RFP) that resulted in five (5) bids being received on January 20, 2012. In addition, an inventory of the "supply side" of health care services is being completed by two Brown University graduates. Staff is developing supply, utilization, and benchmark data for the development of a comprehensive statewide health plan.

Secretary Costantino indicated that the $150,000 was tied to planning within the CON process. He indicated that when decisions are made by the Health Services Council, need is determined by the applicant. The Department of Health has hired consultants in the past to assist in determining need, but there are no tools {such as a statewide health plan} available to the Council if the services or equipment are new. The genesis of the $150,000 was to allocate money for planning for decision making within the CON process.

The RFP requested that potential vendors produce one or more gap analyses for the following 12 services, within a budget of $150,000: primary care services; hospital inpatient services, including specialty care services; hospital outpatient services; emergency department services; technology services (such as robotic surgery and imaging scanners); surgi-center services; nursing facilities;

assisted living residences; home and hospice care services; behavioral health care services; health care workforce development; and the impact of environmental issues upon health status.

Within the RFP, potential vendors are asked to research the current status of the topic selected, evaluate service delivery patterns, review national and state standards, target best practices, support findings with quantitative data and implement focus groups and surveys, as applicable.

It is important to note that $150,000 will not be sufficient to produce an entire statewide health plan. The selection of a vendor will assist in estimating the total cost of a statewide health plan. A longer timeline might be implemented if the General Assembly appropriates additional funds in 2012 and beyond.

An interim report should be available from the successful vendor in May 2012. The Governor and the General Assembly are scheduled to receive the final gap analysis report in July 2012.

Council Comments and Input

Dr. Wetle, who chaired the 2007 health planning committee, indicated that that past planning group was very diverse, with many varied interests. There was unanimous support for the 2007 report (referenced above).

Mr.Belcher indicated that the "triple aim" is hard to argue with; no one should argue against it. He hopes to achieve collaboration among those who provide health care and those who pay for the care.

Mr. Andruskiewicz indicated that Blue Cross/Blue Shield of Rhode Island is very supportive of this effort. The health care system will not transform itself without planning. Planning is critical for system transformation.

Dr. Klatzker: It is an exciting time in Rhode Island, with a multitude of health care reform processes underway. All of this effort is flowing towards same goal: the "triple aim."

Dr. Flanagan: Child health services should be included on the list in the RFP gap analysis.

Mr. Reynolds: Traditional planning approaches are not particularly helpful in predicting future needs. Ten years ago, a great need for cardiac facilities might have been predicted. But, there has been a downturn in these services. He suggests going back to the "triple aim" and measuring inputs.

Dr. Ganim: She lived through the first health planning process. The most discouraging part was the development of a long-term vision, but no decision making followed. The CON process moves forward, but there are no conduits for planning and decision making. In this instance, data and linkages need to be made for system reform.

Dr. Flanagan: The supply side inventory is an acceptable place to start, but there is clear agreement that there is no health care "system."

Dr. Keenan: With an inventory, we will have "what is"; the goal is to have "what we want." We will have to identify the disconnect between the two.

Dr. Klatzker: It is a noble effort to start somewhere. A small bite is better than no bites at all. The RFP will give us a feel of "what costs what" so we have a feel for what resources will be needed to cover the universe in a coordinated statewide health plan.

Mr. Andruskiewicz: We need to do baseline data collection. What is the current health status of the Rhode Island population?

Mr. Charbonneau: In the RFP, we could be vulnerable because we are choosing a few topics from the list of 12 items. He suggested dredging up the SHAPE study previously prepared by consultants Booze, Allan and Hamilton. The SHAPE study could be a building block for this process.

Mr. Belcher: "Stay on the triple aim."

Dr. Wetle: In the 2006-2007 planning process, the group focused on the "triple aim." Dr. Wetle values the time spent on this activity. It might be useful to review these values and principles from the last planning effort.

Mr. Reynolds agrees with Dr. Flanagan: In addition to establishing group principles, there may be specific deliverables that the Council may need or want to produce.

Dr. Keenan: Does the group agree with the planning vision already created? This new Council may want to "re-tweak" the vision and build upon the vision already created.

Mr. Belcher: If we have clarity about a vision, the inventory will provide components of what services we have now. We can get ourselves started along a road.

Ms. Hayward: This has been a very interesting conversation. Next time the group meets, it would be helpful to have a presentation of past work done, vision, and principles; and the group needs to put data on the table regarding outcomes. This may provide us the opportunity to determine next steps and move forward. She does not want the group to get bogged down in a discussion of "what we don't have."

Next Meeting

It was suggested that for the next meeting, a presentation of the past group's vision would be useful. It would ground the group in past work and validate it again with this group. This group wants to follow on with previous work. The Council will also receive an update on the RFP process.

The Council will meet approximately every sixty (60) days. No future meeting dates have been established yet for the Council.

Follow-up Items

Dr. Flanagan would like to see a copy of the RFP.

Ms. Bourque would like to review other states' planning documents. She believes there are rudimentary questions to answer.

Other states to look at might include: Vermont that has a single insurance exchange, rate setting, and a comprehensive planning process. Rochester, New York has completed many health planning activities. It has the last health systems agency in the United States, and it administers a CON process. States to focus on for examining excess hospital capacity include New York and New Jersey.

With no further discussion, the meeting adjourned at 2:35 pm.

Notes prepared and respectfully submitted by:

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Executive Office of Health & Human Services
February 14, 2012

PRELIMINARY HEALTH CARE PLANNING AND ACCOUNTABILITY ADVISORY COUNCIL

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[1] List current as of June 8, 2012